CONFIDENTIAL PERSONAL DATA

Name:_____ Date:_____

Client:_____

Last Name First Name Middle Initial

Responsible Party (if a Minor):_____

Street Address:_____

City:_____State:_____Zip Code:_____

Phone: Home:_____ Office:_____

Mobile:_____ Other:_____

E-mail:_____

Client Information:

Date of Birth:_____ Age:_____ Sex:___M___F Marital

Status:___Single___Married___Divorced_Separated____

. . . . . .

_____ _____

Signature of Responsible Party **Date**

Financial Responsibility and Retainer Agreement

Fees:

Fees for service shall include, but not be limited to charges for consultations, interviews, evaluation appointments, collateral appointments, broken and canceled appointments, testing, test scoring, test interpreting, reviewing printed materials, reviewing documents, preparing and providing reports, affidavits, testimony, and staff and research assistant time. The fee schedule for all services by Dr. Silverman is included on a separate page.

The financially responsible party shall pay the fees for all time and services, whether the time spent in the service is initiated by that party, another attorney, the court, or other persons or agencies relevant to the matter.

Retainer:

There is a minimum retainer of **$4,000** for each matter. The retainer is to be paid before Dr. Silverman may be identified as having been consulted with or retained in the matter. Appointments with Dr. Silverman will be canceled without notice if this retainer is not paid at least 5 business days before the first consultation or evaluation appointment. The retainer is a credit balance against which fees shall be charged. Of the retainer, the minimum of $1500 is non refundable should the consultation or evaluation be canceled or not completed for any reason at any time by any party or attorney other than Dr. Silverman. Dr. Silverman shall return any unused remaining portion of the retainer to the payer promptly when requested and when notified by the responsible party in writing that Dr. Silverman's services will no longer be required in the matter. If Dr. Silverman's fee meets the initial retainer, additional retainers shall be required. Additional retainers and fees shall be paid promptly when requested by Dr. Silverman. Services will be suspended if future retainers or fees are not paid when requested. Testimony, reports, and opinions will not be released until account balances are current.

Payment:

Payment is due and payable at the time of service. Service charges will accrue at 1.5% per month but not to exceed the amount permissible by law, on any balance not paid within 30 days after the charge was incurred.

Financial Responsibility and Third Party Payments:

The financially responsible party is_____ in the matter. Health
(*Print Name*)
insurance does not cover forensic examinations and the attempt to seek insurance coverage is not a substitute for any of the financial obligations described herein. The acceptance by Dr. Silverman of payments from a third party shall be construed only as payments made by the third party on the behalf of the financially responsible party and not as indication that the third party is the financially responsible party.

Appointments and Cancellations:

Because the scheduled appointment time is held exclusively for one person or task, the advanced notice of cancellation is required. Cancellation charges are as follows: 24 hours in advance for a 1 hour appointment. Full payment is required for same day cancellations. For more than an hour of scheduled time, 3 business days notice is required or there will be a full charge for those hours. A minimum of 2 hours is charged for each court appointment.

Collection:

If an amount is due for 30 days, it shall be sent for collection. The responsible party shall pay all reasonable costs of collecting the bill such as a reasonable collection agency fee or reasonable attorney fees and court costs.

Termination:

Dr. Silverman may immediately and without prior notice terminate his services and contact any time he has reason to believe that any party is not fully complying with the provisions stated herein or with the orders of the court. Since Dr. Silverman is retained by the attorney and his professional liaison with the court is an attorney, Dr. Silverman may at his sole discretion immediately terminate his service of any party related to this matter that is not or ceases to be represented by council. No services will be provided after services are terminated for any reason.

_____ _____

Signature Date

INFORMED CONSENT FOR FORENSIC ASSESSMENT

Your attorney has asked that I conduct a psychological assessment in connection with your court case. This form was written to give you information about the assessment process. The assessment usually contains two parts, an assessment interview and psychological testing. During the interview I will ask you questions about yourself and/or anyone else that may be relevant to your case. There may be topics that you may not wish to talk about. If there are, please let me know and I will ask no further. We can also talk about any concerns that you have.

During the interview I may not ask about some areas of information that you believe are important. Please let me know so that we can discuss them. I may also obtain what is called collateral information form friends, relatives, or other people including employers or school personnel regarding your case. Please let me know if you have any objections.

I am a psychologist licensed by the State of Florida. I am also Board Certified in Clinical Psychology. You may feel free to ask your lawyer for a copy of my resume.

Please check each item below to indicate that you have read this form and understand it:

☐ I understand that Dr. Wade H. Silverman has been hired by my attorney,_____, to conduct a psychological assessment and a clinical interview.
☐ I understand that Dr. Wade H. Silverman will write a formal report about me based on the results of his assessment.
☐ I authorize Dr. Wade H. Silverman to send a copy of this formal report to my attorney and to discuss the report with him or her.
☐ I understand the Dr. Wade H. Silverman will not provide me with the written report but I may, if I choose, obtain it from my lawyer.
☐ I authorize Dr. Wade H. Silverman to testify about me and this assessment in depositions and trial(s) related to my legal case.
☐ I understand that if I disclose certain types of special information to Dr. Wade H. Silverman, he may be required or permitted to communicate this information to other people. As previously discussed with Dr. Wade H. Silverman, examples of such special information include reports of child or elder abuse and threats to kill or violently attack a specific person.

If you have read, understood, and checked off each of the prior actions, please read carefully the following statement and, if you are in agreement, please sign the statement.

Do not sign if you have any further questions or if there are any aspects that you don't understand or agree to: contact your attorney for guidance concerning how to proceed so that you fully understand the process and can decide whether you wish to continue.

Consent Agreement: I have read, agreed to, and checked off each of the previous sections. I have asked questions about any parts that I did not understand fully. I have also asked questions about any parts that I was concerned about. By signing below, I indicate that I understand and agree to the nature and purpose of this testing, how it will be reported, and to each of the points listed above.

_____
Signature Date

_____
Name (Please Print)